Wisconsin Department of Safety and Professional Services
Boxing and Mixed Martial Arts
P.O. Box 8935
Madison, WI 53708-8935.

Phone: 608-261-8503
Email: dspscombativesports@wisconsin.gov
Web: http://dsps.wi.gov

Boxing OR Mixed Martial Arts Contestant License

Your application will not be processed or will be delayed unless you:

[ ] 1. Complete the application information section on the first page. You must complete all sections including your social security #.
[ ] 2. Complete the certification of legal status section on this application.
[ ] 3. Complete the contestant's prior bout history on this application.
[ ] 4. Affidavit of applicant and consent for release of medical information
[ ] 5. Attach the $40 credential fee, Make checks payable to: State of WI – DSPS, to this application and mail to the address listed on the first page.
[ ] 6. Complete and attach the medical examination report at the end of this application.

Note: The Department may request additional information necessary to determine an applicant's eligibility for a license, such as additional medical reports, training, personal interviews and observation of training.

1. Applicant Information (Print in ink or type)

Check credential type you are applying for (Check one):
☐ Amateur Mixed Martial Arts (276) ☐ Professional Mixed Martial Arts (277) ☐ Professional Boxing (263)

Applicant's Social Security #:	Applicant's Date of Birth:	Applicant's Name (First, Middle and Last):
Street Address or PO Box:		
City State Zip Code		Country, If Other Than United States:
Telephone Number (Including area code)		Fax Number (Including area code):
E-mail Address:		

☐ Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. State § 440.14).

Have you ever held a contestant license in the State of Wisconsin? ☐ Yes ☐ No
If yes, please provide the number: _____

The department may not disclose the social security number collected above except to the Department of Children and Families for purposes of administering the child and spousal support program and to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes.

Send application and payment to: Wisconsin Department of Safety and Professional Services, Attention Adam L Burkhalter, P.O. Box 8935 Madison, WI 53708-8935.
Overnight mail delivery and Office location: Wisconsin Department of Safety and Professional Services, Attention Adam L Burkhalter, 1400 East Washington Ave, Madison, WI 53703
All other correspondence:
Phone: 608-261-8503, ***TTY: Contact through Relay,*** Fax: 608-223-6532, online: http://dsps.wi.gov or by email: dspscombativesports@wisconsin.gov

For Receipting Use Only

#147 (Rev. 1/13) (CH.440, Stats and Ch. 444, Stats)

Eligibility to obtain the credential: A person who applies for a contestant's license shall do all of the following:

- Be at least 18 years of age.
- An Association of Boxing Commission's mixed martial arts national identification number is required before participating in a scheduled contest. If you do not have an identification number, an application form is available on our website. A $20 processing fee is required and a photo must be emailed to the Department to print your id.
- Provide results of a physical examination by a physician and laboratory results conducted no more than 90 days before the date of the application in accordance with ch. 448, Stats. This information can be recorded under the medical exam section on this application.

2. Certification of Legal Status:

I declare under penalty of law that I am (Check one):

☐ a citizen or national of the United States, or

☐ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

3. Contestant's Prior Bout History:

1. What is the contestant's record?
   _____ Wins _____ Losses _____ Draws _____ KO's

2. What is the date of the contestant's last bout? _____

3. If the contestant has never professionally fought, or has not fought within the last five years, please provide information relating to boxing or mixed martial arts training.

4. Affidavit of Applicant and Consent for Release of Medical Information

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

_____ _____

Applicant's Signature Date (mo/day/yr)

I, _____ (Print Name) , hereby authorize any physician, staff, or any other medical professional who provided the results of my physical, lab work, or any medical documentation from other commissions to provide the Wisconsin Mixed Martial Arts Commission, or any member thereof, and the Wisconsin Department of Safety and Professional Services, or any attorney, investigator, employee, or agent thereof, 1400 East Washington Avenue, Madison, Wisconsin, with copies of all documents regarding my medical and treatment records. This includes but is not limited to: intake summary; physicians' progress notes; laboratory tests; x-rays; consultation reports; nursing notes; medications prescribed; discharge summary; diagnosis and prognosis records; and collection, submission and analysis reports of body fluid screens. This is to include records relating to HIV testing and treatment, if such treatment has been given.

This disclosure is being made for the purposes of receiving a license to fight as a mixed martial arts contestant and any legal investigation needed to verify information submitted to support such application for license or subsequent medical treatment. Unless revoked earlier, this consent regarding records is effective for one (1) year from the date of my signature. I understand that I may revoke this consent at any time and that information obtained prior to revocation as a result of this consent may be used after the above expiration date or revocation. A reproduced copy of this consent form shall be as valid as the original.

I further authorize discussion with the above-listed persons regarding any matters relating to my treatment.

_____ _____

Applicant's Signature Date (mo/day/yr)

5. Credential Fee (nonrefundable): $40.00

Make checks payable to: State of WI - DSPS. The credential will be effective for 1 year from the date of issuance. A new application must be submitted to renew the license.

6. Contestant Medical Examination Report:

Name:	Birth date:

Please answer the following questions:

1. Are you 35 years of age or older? ☐ **Yes** ☐ **No**
   If yes, you are required to submit the results of a CAT scan (CT) with contrast or MRI examination in addition to all the other required medical examinations listed below.

2. Are you 39 years of age or older? ☐ **Yes** ☐ **No**
   If yes, you are required to submit the results of the following examinations in addition to all the other required medical examinations listed below:
   - MRI/MRA brain examination
   - Metabolic blood profile
   - A stress echocardiogram examination with the cardiology clearance
   - A chest x-ray that has been given within 2 years

3. Have you had any illness or injuries within the last 5 years? ☐ **Yes** ☐ **No** If yes, describe: _____
4. Have you ever had severe headaches, fainting spells, or dizziness? ☐ **Yes** ☐ **No** If yes, describe: _____
5. Do you have any medical condition that may affect your ability to compete? ☐ **Yes** ☐ **No** If yes, describe: _____
6. List your record: **Amateur** _____ **Professional** _____
7. What is the date of your last bout? _____
8. Have you ever been injured in a bout? ☐ **Yes** ☐ **No** If yes, describe injury: _____
9. Have you ever been knocked out? ☐ **Yes** ☐ **No** If yes, date of last knock out _____ How long were you unconscious? _____

Your physician must complete the remainder of this form in its entirety, including the results from your blood tests. This completed form and any additional examination results must be submitted with the application.

Vitals		
Height:	Pulse:	Blood Pressure:
Weight:	Temperature:	
Comments:		

Tendon Reflexes	
Knee Jerk: Normal or Abnormal	Rhomberg: Normal or Abnormal
Babinski: Normal or Abnormal	Finger to Nose: Normal or Abnormal
Comments:	

Extremities / Joints			
Hands: Normal or Abnormal	Elbows: Normal or Abnormal	Feet: Normal or Abnormal	Ankles: Normal or Abnormal
Wrists: Normal or Abnormal	Shoulders: Normal or Abnormal	Knees: Normal or Abnormal	Hips: Normal or Abnormal
Comments:			

Misc		
Mouth and Pharynx: Normal or Abnormal	Adenopathy: Normal or Abnormal	Heart: Normal or Abnormal
Abdominal Palpation: Normal or Abnormal	Testis: Normal or Abnormal	Lungs: Normal or Abnormal
Boils, Herpes, Impetigo: Yes or No	Hernias: Normal or Abnormal	
Comments:		

Eyes	**Left**	**Right**	**Comments**
Distant Vision	20/	20/	
Light Reflex	Normal or Abnormal	Normal or Abnormal	
Accommodation Reflex	Normal or Abnormal	Normal or Abnormal	
Cataracts	Normal or Abnormal	Normal or Abnormal	
Fundi	Normal or Abnormal	Normal or Abnormal	

Bloodwork	**Date Drawn**	**Date of Results**	**Results**	**Comments**
HIV			Negative or Positive	
Hepatitis B surface antigen			Negative or Positive	
Hepatitis C antibody			Negative or Positive	

PLEASE CHECK ONE: ☐ **I have** ☐ **I have not medically cleared** _____ **to engage in combative sports.**
(Name)

Physician Information:
Examiner Name (Printed): _____ Title (M.D., D.O., P.A.) & Lic #: _____

Address: _____ Phone: _____

Date of Exam: _____ Examiner Signature: _____